STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155611	A. BUILDING 00 B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER CHRISTIAN VILLAGE	621 SOUTH SUGAR ST BROWNSTOWN, IN47220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 8, 9 and 10, 2011 Facility number: 000277 Provide number: 155611 AIM number: 100290530 Survey team: Melinda Lewis, RN, TC Marla Potts, RN Sharon Whiteman, RN Jill Ross, RN Census bed type: SNF: 6 SNF/NF: 84 Total: 90 Census payor type: Medicare: 6 Medicaid: 70 Other: 14 Total: 90 Sample: 18 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Please consider tthis plan offi correctton as Hoosier Christtan Village's credible allegatton offi compliance. This plan offi correctton constttttuttes a written allegatton offi substtanttal compliance under Federal Medicare and Medicaid requirementts. Submission offi tthis plan offi correctton is nott an admission tthatt a defficiency existts or tthatt tthe communitty agrees tthey were citted correcttly. This plan offi correctton reffiectts a desire tto conttnuously enhance tthe qualitty offi care and services provided tto our residentts and are submitted solely as a requirementt offi tthe provisions offi Federal and Sttatte law. Please acceptt tthis evidence in lieu offi an onsitte ffiollow up visitt ffior Recerttfficatton and Sttatte Licensure Survey Eventt ID WYK711 on Augustt10, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on August 12, 2011 by Bev Faulkner, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to immediately notify a physician of a new open area for 1 of 18 residents reviewed for notification, in the sample of 18. Resident # 40	F0157	F157 Itt is tthe policy offi Hoosier Christtan Village tto immediattely inffiorm tthe residentt, consultt witth tthe residentt's physician, and iffi known, nottffiy tthe residentt's legal representtattve, or an intterestted ffiamily member	09/02/2011

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	Findings include: The clinical record for Resident # 40 was reviewed on 8/8/11 at 11:00 A.M. The record indicated Resident # 40 had diagnoses that included but were not limited to dementia with behavior changes, anxiety and depression. The MDS [Minimum Data Set] assessment, dated 7/28/11, indicated Resident # 40 had no impairment in her cognition, was independent with bed mobility and had an unplanned weight loss. The Nurses Notes, dated 7/30/11 at 1900 (7:00 P.M.), indicated "Reported to me by nursing assistant B [bilateral] upper coccyx measuring 0.3 x [by] 0.5 cm, 0.5 x 0.6 cm, and 0.4 x 0.7 cm. Three small open areas applied extra protective cream. Faxed MD awaiting..." A Physician Order, dated 8/1/11, indicated "...Magic Butt cr [cream] to buttocks q [every] shift until healed then prn [as needed]." In an interview with the Director of Nursing, on 8/8/11 at 11:50 A.M., she indicated the nurse should have telephoned the physician of the open areas instead of faxing the physician. The facility policy and procedure for		when tthere is an accidentt involving tthe residentt which resultts in injury and has tthe pottenttal ffior requiring physician intterventtion; a signiffficantt change in tthe residentt's physica, mentta, or psychosocial sttattus, a need tto altter ttreattmentt signiffican, ttly or a decision tto ttransffier or discharge tthe residentt ffirom tthe ffiacilitty as speciffied in 483.12. 1. On Augustt16, 2011 tthe skin assessmentt on Residentt #40 revealed tthatt skin is inttactt witthoutt any redden areas 2. All residentts have tthe pottenttal tto be affiectted by tthis alleged defficiency 3. On Augustt08, 2011 tthe D.O.N. gave 1:1 re-inservicing tto tthe nurse who, on 7/30/2011, ffiaxed tthe MD regarding tthe superfficial small open areas on Residentt#40; tthe inservice included tthe ffiacilitty's policy and procedure ffior Change in Conditton and nottffficatton offi physician. On Augustt24, 2011 nurses were reeducatted by tthe D.O.N. on	

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	Change in Condition- Physician Notification, dated 7/1/05, was provided by the Director of Nursing, on 8/10/11 at 11:30 A.M. The policy indicated "...Physician notification is to include but is not limited to:...Onset of pressure ulcers...The nurse will document in the clinical record. Documentation will include, but is not limited to; the assessment of resident condition, physician notification, and physician's plan, including orders." 3.1-5(a)(3)		tthe ffiacilitty's policy and procedure ffior Change in Conditton and nottfficatton offi physician and documenttng on tthe 24 hr.reportt log 4. The RN Supervisors on day and evening shiffis and medical records will monittor tthe 24hr.reportt log every shiffi,ongoing, tto auditt ffior residentt change offi conditton and nottfficatton offi physician any ffindings will be broughtt tto tthe CQI committee ffior ffiurtther review and/or recommendattons. 5. Completton datte 9/02/2011	

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure residents at risk for falls and elopement were supervised to prevent elopement and interventions were implemented to prevent repeated falls for 2 of 18 residents reviewed for supervision and fall prevention strategies in the sample of 18. (Resident #60 and #84) This failure resulted in Resident #60 eloping from the facility and falling causing facial lacerations requiring four stitches to upper left eye. Findings include: 1. The clinical record for Resident # 60 was reviewed on 8/9/11 at 11:00 A.M. The record indicated Resident # 60 had diagnoses that included but were not limited to Dementia- Alzheimer's type,	F0323	F323 Itt is tthe policy offi Hoosier Christtan Village tto ensure tthatt tthe residentt environmentt remains as ffiree offi accidentt hazards as is possible; and each residentt receives adequatte supervision and assisttance devices tto preventt accidentts 1. The intterdisciplinary tteam mett and reviewed Residentt#60 plan offi care tthatt included 1:1 supervision during waking hours witth every 15 minutte checks while asleep, bed alarm on, assistt residentt tto tthe batthroom upon wakening in a.m., affier meals, att bedttmę and when resttlesş ambulatte residentt witth gaitt beltt and ttwo assistts	09/02/2011

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	anxiety, and dementia with aggressive behavior. The MDS [Minimum Data Set] assessment, dated 6/16/11, indicated Resident # 60 had severely impaired cognition. Resident # 60 required limited assistance of one with bed mobility, extensive assistance of two with transfers, ambulation and toilet use. Resident # 60 had fallen three times since the previous assessment; two falls with no injuries and one fall with injuries. A Neuropsychology Testing Report, dated 3/10/11, indicated "...Her cognitive status significantly worsened with her apparent head injury from a fall this January...." A Resident Fall Risk Assessment, dated 4/12/11, indicated a score of 28. The form indicated "over 13 points = At risk." The Admission Orders and Plan of Care, dated 4/11/11, indicated "...Wanderguard at all times..." An Elopement Risk Assessment, dated 4/12/11, indicated one of the ten questions was answered yes, with the other nine questions answered no. The form indicated "Resident with more than 5 'YES' answers or any 'YES' response to a * (asterisks) statement are at high risk for elopement. Proceed with elopement interventions." The one question		affier meals ffio15 minuttes, keep room, patthways uncluttered, assure residentt wears proper ffioottwear ffior ttransffiers and ambulattn, keep personal and ffirequenttly used ittems witthin residentt's reach, non skid sttrips on ffioor beside bed. On 5/07/2011 Residentt#60 was moved tto a room down tthe hall ffiurtther away ffirom an exitt dopno ffiurtther attemptts tto exitt tthe building since 5/06/2011. On 8/22/2011 Residentt#60 acttvitty plan offi care was updatted tto includ: Affier walks witth sttaffi1:1 witth residentt, residentt enjoys looking tthru golffi magazins, wattching birds in tthe aviary, sorttng hair rollers, playing witth cards, and counttry music. During hours offi tthe nightt when residentt wakens offier drinks witth snacks, play relaxatton CDs in room. The intterdisciplinary tteam also reviewed Residentt#82 plan offi care tthatt includedanttroll back devices on wheelchair, assistt residentt tto ttoilett upon	

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	answered 'YES' did not have an *. A Care plan, dated 4/12/11, indicated a problem of "Potential for fall R/T [related to] Hx [history] of falls, dx [diagnosis] of Alzheimer's and psychotropic drug use." The interventions were "Fall protocol. Get rd [resident] up at 0630 (6:30 A.M.). Complete Fall Risk Assessment. Provide assistive devices as needed walker. PT [physical therapy]/OT [occupational therapy] to screen/evaluate/treat per P.O. [physician order]." The Nursing Notes, dated 4/14/11 at 0715 (7:15 A.M.), indicated "Light was on. Went into room to see what she wanted. Had removed personal alarm and was lying on floor on abdomen...0.5 cm ST [skin tear] noted R [right] wrist. No further injuries noted...Did not hit head. Denied having to go to bathroom. Was not incontinent of bowels or bladder." The fall care plan, dated 4/12/11, was updated on 4/14/11 to include the interventions of "concave mattress and non-skid strips on floor." A Care plan, dated 4/19/11, indicated a problem of "Impaired safety with risk for falls and elopement r/t [related to]: Diagnosis of Alzheimer's dementia, unsteady gait, poor standing balance,		rising, affier meals and att bedttme and bettween2100 tto 2200, offier hs snack and ffiuids,keep room uncluttered, ensure proper ffioottwear receiving physical ttherapy ffior sttrengtthening,bed alarm on, encourage tto ambulatte witth ttwo assistts affier meals as ttoleratted.On 8/17/2011 Residentt#82 was insttructted on how tto use tto saffietty release beltt witth an alarm. Residentt was able tto release tthe beltt witthoutt difficultty and verbalizes understtanding offi tthe alarm sounding tto remind sttaffi she needed assisttance tto gett up.The acttvitty plan offi care ffior Residentt#82 was updatted tto include: Encourage residentt tto parttcipatte in painttng sttttchery or needlework in latte affiernoons, assistt tto Bingo every Friday, assistt tto gospel singing every Tuesday and Sunday, play gospel music soffily in room iffi awakens during tthe nightt.Offier ffiood, ffiuids,assisttance tto ttoilett iffi awakens during tthe nightt	

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	decreased muscle strength, history of falls, and administration of psychotropic drugs." The approaches included but were not limited to: "Complete elopement risk assessment quarterly. Wanderguard alarm to RLE [right lower extremity]. Monitor location of resident frequently and observe for any safety concerns. Provide 1:1 [one to one] interaction as needed. Encourage resident to engage in activities. Check door alarms promptly. PT [physical therapy] and OT [occupational therapy] services as ordered. Complete fall risk assessment quarterly. Call light within reach. Half rails up at HOB [head of bed] to serve as an enabler. Concave mattress on bed. Non-skid strips on floor beside bed. Resident is a early riser assist out of bed at 0630 (6:30 A.M.) if resident desires. Monitor for unsafe actions and intervene as needed." The care plan was updated on 4-25-11, with interventions of "Bed alarm on bed. Toilet rd after AM meal et[and] lay down if she desires. Monitor freq [frequently] while in bed et assist back up et out to common area upon awakening." The Nursing Notes, dated 5/2/11 at 1300 (1:00 P.M.), indicated "Rd [resident] went out door 6- very resistive to return inside. TLC [tender loving care] given. Staff sitting with Rd offered B.R. [bathroom], fluids and food. Rd crying wants to go		2. No residentts were identtffied as being affiectted by tthe same alleged defficitt 3. During tthe week offi 8/22/11, all residentts were re-evaluatted witth an elopementt risk assessmentt tto ensure accuracy, no ffindings were notted During tthe weeks offi 8/22/2011 and 8/29/2011 all HCV sttaffi were reeducatted on identtfficatton offi residentts who are att high risk ffior ffialls and ttheir individualized plan offi care tto ensure residentt's saffietty During tthe weeks offi 8/22/2011 and 8/29/2011 all HCV sttaffi were reinserviced on tthe Fall Preventton Policy and Procedure. 4. An auditt will be completted by tthe RN supervisors on days and evenings tthatt will include assessing sttaffi tto ensure knowledge offi identtfficatton offi residentts who are high risk ffior	

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	home." The Nursing Notes, dated 5/6/11 at 0045 (12:45 A.M.), indicated "Resident roommate called CNA to room to say resident had gotten up unassisted. Resident noted to have gone out side door. Staff went to find her. Resident found across street from parking area. Resident noted to have fallen and had abrasions and laceration to L [left] side of face. Resident brought back to facility. MD notified and order rec'd [received] to transport to ER [emergency room] for eval [evaluation]. Areas to L face cleansed and ice applied. Res refused to allow staff to further assess for injuries...Areas to L face abrasion on jaw approx [approximately] 3 cm x [by] 1 cm, 2 smaller areas noted higher on cheek. Laceration upper L eye approx 2.5 cm long well approximated." The Nursing Notes, dated 5/6/11 at 0445 (4:45 A.M.), indicated "Res [resident] returned from (name) ER...Res states her L knee is sore and areas to L face sore...Bed alarm on and functioning...Res has 4 stitches noted upper left eye...Stitches to be removed in 5 days. Will cont [continue] to monitor." The safety care plan, dated 4/19/11, was		ffialls and ttheir individualized plan offi care tto ensure saffietty This auditt will be completted daily ffior one week, tthen weekly ffior one montth, tthen every montth ongoing Any ffindings ffirom tthis auditt will be broughtt tto tthe CQI Committee ffior ffiurtther review and recommendattons. 5. Completton datte 9/02/2011.	

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	updated on 5/6/11 to include the approach of "Staff will do 15 min [minute] checks, offer foods, flds [fluids], toileting, and assess for pain." The Nursing Notes, dated 5/10/11 at 1300 (1:00 P.M.), indicated "Abrasions on L side of face and above L eye healing without s/s [signs or symptoms] infection. Areas are dark purple and yellow. 4 sutures above upper L brow intact and 2 areas L cheeck [sic] with ii [two] sutures in each area intact..." The safety care plan, dated 4/19/11, was updated on 5/22/11 to include the approaches of "Ambulate with i [one] assist keep hands on gait belt at all times and Resident rec's [receives] 1:1 [one to one] supervision during waking hours et checked on frequently while asleep." The Nursing Notes, dated 5/24/11 at 0715 (7:15 A.M.), indicated "Got up out of bed and found in doorway between room et foyer. Had blood in hair. Noted 1" [inch] long laceration on L [left] scalp near crown. Alert et [and] talking Didn't fall...." The Nursing Notes, dated 5/24/11 at 0815 (8:15 A.M.), indicated "Dr (name) informed of hitting head on corner of doorway and receiving laceration on L			

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	scalp, approx [approximately] 1" long, near crown of head. Order to send to ER [emergency room] for eval [evaluation] rec [received] and noted..." The Nursing Notes, dated 5/24/11 at 1130 (11:30 A.M.), indicated "Returned to room via (name) ambulance with ii [two] attendants. Has 5 sutures in laceration on scalp." In an interview with the Director of Nursing, on 8/9/11 at 2:30 P.M., she indicated the resident had a Wanderguard on and the door alarm did sound. In an interview with the Director of Nursing, on 8/10/11 at 10:45 A.M., she indicated the bed alarm was sounding at the time of the incident on 5/24/11. The Nursing Notes, dated 7/15/11 at 0410 (4:10 A.M.), indicated "At 0350 (3:50 A.M.) Rd PA [personal alarm] sounded. CNA on hall went to room and resident was not there. Rd found immediately in neighbors across the hall, room sitting on floor. Rd stated she sat down to go to bathroom. No injuries..." The Nursing Notes, dated 7/15/11 at 0413 (4:13 A.M.), indicated "CNA stated resident not on floor on basket peeing.			

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	CNA then stated when done resident got off basket and on floor." [sic] The Nursing Notes, dated 7/15/11 at 0500 (5:00 A.M.), indicated "Dr (name) informed of going into another room et urinating in a wicker basket. Staff came and lowered her to the floor." The Nursing Notes, dated 7/15/11 at 2125 (9:25 P.M.), indicated "Aide was in room with res and res kept sliding her butt down in her recliner and had her butt between the foot rest and cushion of recliner all of a sudden recliner tipped causing res to slide down foot rest hitting her buttocks on floor. Res received i [one] bruise to coccyx and i bruise to L [left] buttock both purplish in color...Intervention is to ask housekeeping if we can get res a new recliner...." The safety care plan, dated 4/19/11, was updated on 7/15/11 to include the approach of "Replace recliner in rm [room]. Toilet rd if restless offer foods and fluids. Ambulate Rd if she desires." A Care plan, dated 7/15/11, indicated "Resident at risk for falls." The interventions were "1.) Keep room, pathways uncluttered. 2.) Encourage to use assistive devices as needed. 3.) Check on resident frequently. 4.) Keep call light			

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	155611	A. BUILDING 00 B. WING	08/10/2011

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within reach. 5.) Assure resident wears proper footwear for transfers. 6.) Assist with toileting as needed. 7.) Keep personal and frequently used items within resident's reach. 8.) Provide adequate lighting. 10.) [sic] Replace res [resident] recliner with a different one that does not jerk was replaced with an electric chair."

In an interview with Nurse Supervisor # 1, on 8/10/11 at 10:50 A.M., she indicated the care plan, dated 7/15/11, with interventions 1 through 8 is what the facility uses as the "Fall Protocol."

On 8/10/11 at 9:40 A.M., the Director of Nursing indicated the Wanderguard system has two doors which lock when a bracelet is near, but all the doors sound an alarm. She indicated Resident # 60 went out the same door on 5/2 and 5/6/11, which was a door that alarms only. She indicated the resident's room had been two doors away from the exit door at the time of the incidents on 5/2 and 5/6/11.

On 8/10/11 at 11:30 A.M., the Director of Nursing provided the Code Alert Systems policy and procedure dated 9/10/08. She indicated the Code Alert System was the Wanderguard system. The policy indicated "...When the door alarm is activated available staff will go to exit door..."
2. Resident #82 was identified by the

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	DON (Director of Nursing) on 8/8/11 at 9:30 A.M. during the initial tour of the facility, as cognitively impaired and not interviewable. Resident #82 was observed on 8/10/11 at 9:15 A.M., sitting in her room in her wheelchair, sleeping. The wheelchair had anti-roll back devices in place. Resident #82 was observed to have on non skid socks. Resident #82's clinical record was reviewed on 8/10/11 at 9:15 A.M. Diagnoses included but were not limited to: "dementia and schizophrenia." The most recent MDS (Minimum Data Set), a change of condition assessment, dated 7/7/11, indicated the resident had disorganized thinking which fluctuated-came and went or changed in severity. The resident had behaviors of physical and verbal behaviors directed towards others. Resident #82 required extensive assistance of two staff with bed mobility, transfers, ambulation, and toiling. The resident was occasionally incontinent of bladder and bowels and did not have a toileting program in place. The resident had two or more falls since the last assessment. The CAA (Care area assessment) review, dated 7/7/11, "falls" included: "...has had			

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	deterioration in adls (activities of daily living)...has been occasionally incontinent of urine...increased mental confusion noted...Resident was not steady, only stabilized with human assistance, when moving on and off toilet, when turning around and facing the opposite direction and when moving from seated to standing...Resident is non-compliant with asking for assistance...staff will give frequent reminders to use call light to request assist and will check on resident frequently..." The resident fall risk assessment, dated 7/7/11, indicated a score of 28, with over 13 points as high risk. The Resident Care Plan, included a problem, dated 4/15/11, for "impaired safety with risk for falls due to diagnosis [sic] of schizophrenia, bipolar, anxiety and other mood disorders with psychotropic drug usage" "5/24/11 res non compliant with asking for help using call light to get assist for transfers." Interventions included: "Staff to check on resident frequently and assist resident as needed. 5/15/11, non skid socks. 5/23, encourage resident to back up to mattress/bed until back of knees touch bed then to sit down, upper side rails up to help with positioning and mobility. 5/24/11, encourage to use call light when			

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	needing up with transfers, check on frequently, encourage res to attend activities lounge area. 5/26/11, 2 assist with transfers, praise for using call light. 6/11/11, give frequent reminders to lock wheelchair, antiroll back device. 6/28/11, toilet after meals ask res if she wants to be assisted to bed or come to lounge after meals. 6/30/11, toilet res at the beginning of every round 930, 130, 0300, 0500 during the night. 7/2/11, ensure resident receives hour of sleep snack or juice prior to going to bed. 8/1/11, supply with a reacher, monitor for loose stool. 8/2/11, when resident goes to activities assist back to unit as soon as activity over." Another problem for falls, dated 8/2/11, indicated interventions of "keep room pathway uncluttered, encourage to use assistive devices, check on frequently, keep call light in reach, assure proper foot wear, assist with toileting as needed, keep personal items in reach, provide adequate lighting." CNA #5, provided the CNA assignment sheet for Resident #84 on 8/10/11 at 11:00 A.M. The assignment sheet indicated the resident required two assist for transfers, remind to lock wheelchair, offer snack at night, check resident first during night rounds to see if toilet needed, toilet before and after meals, non skid socks, remind to use call light, keep light in reach, check			

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	on every 30 minutes, after meals see if wants to go to bed or come to lounge area, monitor room to make sure roommate is not blocking entry to room, toilet residents 9:30 p.m., 11:30 p.m., 3:00 A.M. and 0600 (6:00 a.m.), praise for using call light." A physician progress note, dated 6/2/11, indicated "patient with diminished mental status with increased falling." Nurses notes indicated: 5/14/11 1045 A, " resident found on floor in restroom incontinent of urine...Alert and oriented times 3...non skid socks applied..." 6/3/11 1530 (330 P.M.), "res was found on floor sitting in upright position by bathroom in room, Res was not using walker, wearing on skid socks stated lowered self to floor." 6/3/11 1700 (5 p.m.), "res found on floor in upright positioning by bed...was trying to go to bathroom..." 6/4/11 1725 (525 P.M.), "CNA had placed res on toilet in her bathroom and told her to pull call light when done. Found res sitting on buttocks in doorway of bathroom...stated was going back to her			

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	chair..." 6/4/11 1745 (545 P.M.), "this nurse was walking past res room, res sitting on buttocks on floor beside bed..res reminded she needs to use call light then wait for assistance prior to getting up-voices understanding and able to easily locate light and able to use it appropriately..." 6/7/11 135 a.m., " CNA walking past res room. Res sitting on buttocks on floor beside bed...Res stated 'I slid out of bed trying to get a drink of water.' res call light in reach but res did not use it..reminded to use call light and wait for assist..." 6/11/11 1250 p.m., "found res on floor in her room in front of her bed, w/c on other side of room brakes were not locked, res stated she was putting herself to bed and the w/c slipped out from under her..." 6/12/11 1500 (3 p.m.), "res was found on floor outside room laying on left side..." 6/14/11 1845 (645 P.M.), "found res sitting on knees on floor in room Res stated 'I was moving from chair to wheelchair." "I used my call light' call light was not on..." 6/28/11 1820, "res was found sitting on			

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	floor on buttocks in room (not hers but room that connects to her through the bathroom) resident wheelchair in her room...stated she was getting out of bed..." 6/30/11 5:15 a.m. "res found on floor in bathroom resident stated 'trying to go to bathroom' ...interventions non skid socks." 8/1/11 1045 a.m., "resident was noted at this time sitting on floor with leg out in front of her...stated she was going to the bathroom..." 8/1/11 2400 (midnight), "aide heard noise and entered room and found resident laying on floor in front of sink in her room. Resident was last seen at 2345 (11:45 p.m.) when aides repositioned her in chair and she refused to go to bed." 8/2/11 1455 (255 p.m.), "staff was called to dining room res had gotten up and walked and res fell backwards and hit her head on her wheelchair...received a cut to back of head...stated she fell cause she was going to get her children..." During interview with Nurse Supervisor #1 on 8/10/11 at 11:00 A.M., she indicated the facility had considered a personal alarm on 6/7/11, but felt it would			

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	agitate her more, as the resident had made comments about other residents having the alarms. 3.1-45 (a)(1) 3.1-45(a)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review, the facility failed to ensure a physician order for a treatment to a pressure ulcer was documented in the clinical record, for 1 of 18 residents reviewed for clinical records in the sample of 18. Resident #85 Findings include:	F0514	F514 It is the policy of Hoosier Christian Village to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 1. On 8/08/11 clarification order was received from the MD for treatment for resident #85. 2. All residents have the potential to be affected	09/02/2011

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	Resident #85 was identified by Nurse Supervisor #1, during the initial tour of the facility on 8/8/11 at 9:30 A.M., as having developed a superficial open area on her coccyx. Resident #85 was observed on 8/8/11 at 1:00 P.M. to have a superficial open area on her coccyx. LPN #1 indicated the treatment was the Magic Butt cream. LPN #1 indicated she could not find a physician order for treatment for the coccyx area, but indicated the cream had been ordered on 7/6 for the inner buttocks. Resident #85's clinical record was reviewed on 8/8/11 at 11:30 A.M. Nurse's notes, dated 7/29/11, indicated "2150 (9:50 P.M.) ...CNA's noticed open are on res coccyx. Applied MBC (Magic Butt Cream) and turned off area...MD notified..." A Weekly Wound Documentation form indicated the pressure area started on 7/29/11 as a stage 2 area, 0.7 cm by 2 cm, no depth. The clinical record lacked any physician order or documentation of what the physical had ordered. The "treatment flow sheet" for August 2011 lacked any documentation of a treatment having been completed.		by this alleged deficiency. 3. On 8/08/2011 the D.O.N. gave 1:1 re-inservicing to the nurse, who had written the entry on 7/29/2011 for Resident #85, on documentation and noting physician orders. On 8/24/2011 nurses were re-inserviced on documentation and noting physician orders and including any new physician orders on the 24hr. report log. 4. The RN Supervisors on day and evening shifts and medical records will audit the 24hr. report log every shift ongoing for accuracy on documentation and noting physician orders. Any findings will be brought to the CQI Committee for further review and/or recommendations. 5. Completion date: 9/02/2011	

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	During interview with the DON (Director of Nursing) on 8/8/11 at 2:00 P.M., she indicated after speaking to the nurse who had written the entry on 7/29/11, the nurse obtained an order for the Magic Butt cream to the open area, but failed to write the physician order. 3.1-50(a)(1) 3.1-50(a)(2)			